SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

March 14, 2005

2:00 PM or Upon Adjournment of Appropriations

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item	**Department**
4260	**Department of Health Services—*Selected Public Health Issues as noted***

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Both the Department of Health Services and the Managed Risk Medical Insurance Board will be discussed at several additional hearings. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Thank you.

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I. 4260 Department of Health Services

***Overall Purpose of the Department*:** The goals of the Department of Health Services (DHS) are to: (1) promote an environment that contributes to human health and well-being; (2) ensure the availability of equal access to comprehensive health services using public and private resources; (3) emphasize prevention-oriented health care programs; (4) promote the development of knowledge concerning the causes and cures of illness; and (5) ensure economic expenditure of public funds to serve those persons with the greatest health care needs. These goals are carried out through three key programmatic areas, including the Medi-Cal Program, Children's Medical Services, and Public and Environmental Health.

Summary of Department's Proposed Budget: The budget proposes expenditures of $37.6 billion ($13.6 billion General Fund), or a *net* increase of $280.1 million ($1.019 billion General Fund) over the revised 2004-05 budget. Of the total budget amount, $36.6 billion ($13.387 billion General Fund) is for local assistance.

The Governor proposes state support expenditures of $987.3 million ($264.2 million General Fund) which would support 6,069 authorized positions for an increase of 327 new positions over the revised current-year. Even though the Governor has imposed an unallocated reduction of $11.5 million (General Fund) on the department for 2005-06, expenditures for state support are proposed to grow by $10.5 million over the revised current-year

Summary of Expenditures (dollars in thousands)	2004-05	2005-06	$ Change	% Change
Program Source				
Public & Environmental Health	$862,717	$887,587	$24,870	2.9
Medical Care Services	$33,848,236	$34,067,010	$218,774	0.6
County Health Services	$52,867	$52,867	--	--
Primary Care & Family Health	$1,533,989	$1,556,728	$22,739	1.5
State Mandates	$4	$3,761	$3,757	939
State Administration & Operations	$976,806	$987,341	$10,535	1.0
Totals, by Program Source	$37,274,619	$37,555,294	$280,675	0.8
Funding Source				
General Fund	$12,631,405	$13,651,257	$1,019,852	8.1
Federal Funds	$21,417,896	$20,980,414	($437,482)	-2.0
Special Funds & Reimbursements	$3,225,318	$2,923,623	($301,695)	-9.4
Totals, by Fund	$37,274,619	$37,555,294	$280,675	0.8

A. ISSUES FOR VOTE ONLY (Items 1 through 4)

1. Cannery Inspection

Issue: Pursuant to AB 3027, Statutes of 2004, the budget requests to transfer $1.6 million (reimbursements) to a newly created special fund—the Cannery Inspection Program Fund. Licensing fees presently deposited into the General Fund will now be captured in this special fund for expenditure on DHS licensing activities as noted below. No changes in the program or in the level of service are anticipated. Presently nine positions are funded for these activities.

Existing statute requires the food industry to fully fund the DHS for the inspection of low acid canned foods. The foods inspected under the program are shelf-stable soups, vegetables, meet, fish, salsas, sauces and beverages packed in cans, jars and aseptic packages. The program has been in existence for over 75-years.

Subcommittee Staff Comment and Recommendation: The proposal conforms to recently chaptered legislation. No issues have been raised. It is recommended to approve as budgeted.

2. State Administration of the Women's, Infants and Children (WIC) Supplemental Food Program

Issue: The budget proposes to redirect $527,000 (federal funds) from operating expenses to fund 7 positions (two permanent, three for six-months, and two for 18 months). The positions include (1) 1.5 Public Health Nutrition Consultant II positions, (2) two Associate Governmental Program Analysts, and (3) two information systems analysts-related positions. All of the positions are limited-term.

The DHS states that the positions would be used as follows:

- *Local Agency Support (1):* A Public Health Nutrition Consultant position would be used to monitor and support local WIC programs to meet federal requirements. The position would perform on-site monitoring evaluations, conduct on-site technical assistance in nutrition areas, review the training and competency of local agency staff, and monitor contracts.

- *Staff for Food Cost Containment (4)*: Four of the positions would be used to implement new requirements of the Child Nutrition and WIC Reauthorization Act of 2004. This Act requires states to achieve food cost containment through the management of high cost grocers and imposes an 18-month implementation deadline on states for meeting the requirements. Specifically, this Act mandates implementation of a grocer peer group and reimbursement system that distinguishes between high price grocers and competitive grocers. These staff will develop and implement cost containment policies in accordance with the Act, monitor grocer

redemption, develop and implement state regulations, hire and oversee a contractor to perform specialized item processing services and ensure that the necessary infrastructure is in place.

- *Staff for Breastfeeding Peer Counseling (2):* The DHS states that California is still far below the needed rates for women who breastfeed for six months to a year as recommended. The DHS wants to use staff to support local WIC programs in hiring and training breastfeeding peer counselors. Thirty-six other states have implemented this approach and numerous studies document its effectiveness.

Background on WIC: WIC is 100 percent federal fund supported. It provides supplemental food and nutrition to low-income women who are pregnant and/or breastfeeding, and for children under age five who are at nutritional risk. WIC is not an entitlement program and musts operate within the annual grant awarded by the USDA.

The goal of WIC is to decrease the risk of poor birth outcomes and improve the health of participants during critical times of growth and development. The amount and type of food WIC provides are designed to meet the participant's enhanced dietary needs for specific nutrients during short but critical periods of physiological development.

WIC participants receive services for an average of two years, during which they receive individual nutrition counseling, breastfeeding support and referrals to needed health and other social services. From a public health perspective, WIC is widely acknowledged s being cost-effective in decreasing the risk of poor birth outcomes and improving the health of participants during critical times of growth and development.

Subcommittee Staff Comment and Recommendation: The request for the staff is reasonable and no issues have been raised. According to the DHS, the funds being redirected to fund the staff positions are from contract services that are not needed at this time. It is therefore recommended to approve as budgeted.

3. Electronic Death Registration System

Issue: The budget requests an increase of $225,000 (Health Statistics Fund) to fund efforts at the local level and to train system users to ensure the successful integration of the Electronic Death Registration System. Specifically, these funds will be used to contract for services to enroll users (Local Registrars) and provide training on the new system. A total of $1.463 million (Health Statistics Fund) is appropriated for the Electronic Death Registration System.

Chapter 857, Statutes of 2002 (AB 2550, Nation), mandates the DHS to, among other things, develop and maintain an Electronic Death Registration System. AB 2550 provided for increased revenues for this purpose.

Subcommittee Staff Comment and Recommendation: The proposal is reasonable and no issues have been raised. No fees are being increased. It is recommended to approve as budgeted.

4. County Medical Services Program (CMSP)

Issue: The Governor proposes to suspend for another year the $20.2 million (General Fund) appropriation for the County Medical Services Program (CMSP). This $20.2 million has been suspended for the past several years.

The County Medical Services Program (CMSP) provides medical and dental care to low-income "medically indigent" adults who reside in small counties (total of 34 counties) (populations of 300,000 or less, with a few exceptions) and are not eligible for Medi-Cal. The responsibility for providing these services was transferred from the state to the counties as of January 1, 1983.

The CMSP Governing Board is responsible for the administration of pooled funds from the participating counties to provide services to over 65,000 CMSP participants.

Revenues to support the CMSP come from several sources, including County Realignment Funds (i.e., sales tax, vehicle license fees, and growth account), Proposition 99 Funds (selected accounts), Member County Participation Fees, and the General Fund (on deferral for the past 4 years). In 1993 as part of an overall agreement with the counties, the state capped its participation in the local assistance portion of the CMSP at $20.2 million General Fund. The last time the state actually provided the General Fund support was in 1999.

Subcommittee Staff Comment and Recommendation: This proposal is consistent with prior years when the state has chosen not to provide any General Fund support to the program. It is recommended to approve as budgeted, including technical trailer bill legislation. The trailer bill legislation is the same language as has been used in past years and just includes one more year of deferral.

B. ISSUES FOR DISCUSSION

1. Governor's Proposed Elimination of the CA Office of Binational Border Health

Issue: The Governor proposes to eliminate all General Fund support—i.e., $694,000—from the California Office of Binational Border Health (COBBH) which would eliminate all contract positions at the University of San Diego for the COBBH and in effect, eliminate the entire function of the office. The Governor's action would only retain some federal bioterrorism funds which are specifically earmarked for the state's Early Warning Infectious Disease Surveillance Program. The only rational for the proposed action to eliminate the COBBH is to reduce General Fund expenditures.

The existing $694,000 (General Fund) is used to fund contracts with (1) the University of California, San Diego ($569,000), and (2) the County of Los Angeles ($40,000). The DHS states that the balance of the funds (i.e., $90,000) were not encumbered under contracts as it was part of a DHS General Fund cut drill.

When quarried about whether additional federal bioterrorism funds could be used for the COBBH, **the DHS** stated the following:

- The scope of the existing bioterrorism preparedness activities are addressed by the Early Warning Infectious Disease Surveillance (EWIDS) Program. The DHS said that the CDC provided a similar set aside for all other states sharing a border with Mexico or Canada. Specifically, the DHS has a $1.182 million (federal funds) contract with UC San Diego to conduct the EWIDS Program through the COBBH, and the DHS supports two state positions for $246,000 (federal bioterrorism funds).
- With respect to continuation of the EWIDS Program total funds of $1.4 million (federal bioterrorism funds), the DHS was non-committal as to whether even these funds would be continued into 2005-06 since the CDC grant process is not at all clear at this time (This is discussed in Agenda Item 2, below).
- The CDC strictly reviewed the state's use of federal bioterrorism funds in this area and noted to the DHS that California could not supplant existing OBBH efforts with federal funds.

Background—CA Office of Binational Border Health It has long been recognized that the health and well-being of communities on both sides of the U.S.-Mexico international boundary are intertwined and inextricably linked. The California-Mexico border region is a tremendous area of human contact where two cultures meet, flow back and for the across political borders, share common experiences, economic and environmental conditions, as well as, health and disease. San Diego has the busiest border in the world with over 60 million crossing in 2001.

Disease knows no boundaries and because it is a porous border, the regional can be considered an epidemiological area for approaching disease prevention and control, for reducing disease and injury risk factors, and for promoting health.

There has been a State Office of Border Health since 1993. However, AB 63 (Ducheny), Statutes of 1999, formally established the California Office of Binational Border Health in January 2000. The mission of the Office is to protect and improve the health of California communities affected by border or binational conditions and activities through facilitating cooperation between California and Mexico health officials and health professionals. As noted by the DHS, the COBBH serves as the single point of coordination on border health activities.

These efforts included (1) assessing public health status of border and binational communities, (2) coordinating environmental health issues such as air quality, water quality, food safety and lead exposure, (3) mitigating the spread of infectious disease, and (4) promoting health policy and program development for binational cooperation.

The COBBH is strategically located near the California and Mexico border and it has developed expertise and contacts critical to rapid and effective binational infectious disease monitoring and response. These issues include Tuberculosis, West Nile Virus, HIV/AIDS, contaminated food products and environmental health concerns.

Among many other things, the COOBH has participated in (1) investigations of disease outbreaks and food-borne illness concerns, (2) the tracking and monitoring of various health issues, and (3) educational campaigns for immunization programs, access to health care and TB treatment.

Linkage with Bioterrorism Preparedness: Every month millions of people traverse the 140-mile long border between California and Mexico. Improved surveillance for disease on both sides of the border will ensure greater likelihood of diction of an intentional outbreak caused by a chemical or biological agent. Infectious agents released on either side of the border could spread rapidly throughout California and Baja California.

Report—The Border that Divides and Unites: Addressing Border Health in CA: In a recently completed report (October 2004) commissioned by The California Endowment (TCE), the following key aspects were noted:

- Due to distinctive demographic, ecological, social and cultural factors in the border region, a set of special health indicators has emerged that require a binational approach.
- Among the most pressing health issues in the region were public health emergencies, access to health care, environmental health, infectious diseases, HIV and AIDS, substance abuse, mental health, and migrant and agricultural worker health.
- The six-months of research and analysis of this region that was under taken by the contractors pointed to a set of recommendations made in the report, including:
    - Fund and support the creation of a comprehensive border health vision and mission;
    - Support the development of "best practices" in border health and binational health;
    - Support capacity building and training for agencies on establishing partnerships, setting goals, strategic planning and creating a sustainability plan;

- Agencies need to incorporate policies and practices to better integrate a border binational approach to health issues; and
- Increase data collection for research and policy purposes.

Subcommittee Staff Comment: With thousands of individuals crossing the border every day, coupled with the extensive exchange of commerce and goods between California and Mexico, it only makes sense to maintain the COBBH to help ensure public health safety. The importance of the COBBH was highlighted in an independent analysis commissioned by the California Endowment in October 2004 (prior to any budget proposal).

The DHS contends that existing Sacramento-based staff would absorb the responsibilities of the COBBH and thereby, perform the functions now being conducted by COBBH. This is a complete fallacy. First, the DHS has difficulties operating existing public programs with existing staff, let alone absorbing additional responsibilities which pertain to a large, diverse region of California that is over 700 miles away from Sacramento. This region has unique public health challenges that cannot be addressed effectively or efficiently from Sacramento.

Second, the complexity and importance of this region dictates that a comprehensive, single point of coordination is needed. Diffused efforts result in inefficiencies and it derogates from the concept of having a "rapid" response to emerging health concerns.

It is a reasonable investment for California and actually is quite cost-beneficial. The various preventive focused functions performed by the COBBH assist substantially in mitigating the spread of disease in Californians.

Questions:

1. DHS, Please describe the functions of the COBBH and its effectiveness.
2. DHS, Please explain why the budget is proposing to, in effect, eliminate the COBBH?

2. Expenditure of Federal Bioterrorism Funds—State Support & Local Funds

Issues: *First,* the Governor is requesting to extend 94.8 positions for two-years (to June 30, 2007) to continue existing efforts relating to bioterrorism preparedness and response as directed under federal grant agreements with the federal Centers for Disease Control and Prevention (CDC) and the federal Health Resources and Services Administration (HRSA). The DHS is requesting an appropriation of $8.2 million (federal funds) to continue these 94.8 positions in 2005-06.

Presently the DHS has a total of 104.8 positions of which 10 are permanent and 94.8 are limited-term and expire as of June 30, 2005. Of the 94.8 limited-term positions, 76 positions are associated with functions related to the CDC grant and 18.8 positions pertain to the HRSA grant. The remaining 10 permanent positions all pertain to the CDC grant.

The tables below summarize the request to extend (two-years) the 94.8 positions. As noted in the background discussion below, the existing CDC grant has seven "focus" areas and the HRSA grant has four "benchmark" measurements. The requested positions are therefore listed by these areas.

I. CDC Grant and Focus (76 positions)	Positions		Positions
A. Preparedness Planning & Readiness		**D. Laboratory Capacity--Chemical**	
Health Prog Mgr II/III	2	Research Scientist Supervisor IV	1
Environmental Sci IV	1	Research Scientist II/III	2
Medical Officer III	1	Staff Services Analyst	1
Pharmaceutical Consultant	1		7 total
Health Prog Specialst	1	**E. Health Alert Network**	
Staff Services Manager	1	Sr Information System Supvsr	1
Sr Accounting Officer	1	Information System Analysts	1
Associate Gov Analyst	4	Associate Info System Analysts	2
Office Technician	1		4 total
	15 total		
B. Surveillance & Epidemiology		**F. Health Risks & Health Info**	
Medical Officers II/III	3	Health Education Consultant III	1
Research Scientists II/III/ IV	12	Research Analyst II	1
Sr Information Systems Analysts	3	Staff Services Analyst	1
Associate Gov Analyst	2		3 total
Sr Sanitary Engineer	2		
Office Technician	1		
	23 total		
C. Laboratory Capacity--Biologic		**G. Education & Training**	
Microbiologist Specialists	3	Medical Officer III	2
Microbiologist I/II	11	Nurse Consultant III	1
Research Scientist IV	2	Associate Systems Analyst	1
Associate Gov Analyst	1	Associate Gov Analyst	1
Office Technician	1	Office Technician	1
	18 total		6 total

HRSA Grant Positions (18.8 total)	Positions		Positions
Priority Area 1—Program Direction		**Priority Area 3—Laboratory Connectivity**	
Staff Services Manager I	1	Health Program Specialist I	1
Health Program Specialist I	1.5		1 total
Research Analyst II	0.5	**Priority Area 4—Laboratory Data Standard**	
Associate Governmental Prog Analyst	2	Medical Officer III	2
Office Technician	1	Research Scientist III/IV	3
	6 total	Associate Governmental Prog	1
Priority Area 2—Regional Surge Capacity			6 total
Nurse Consultant II	1		
Associate Info Systems Analyst	1		
Health Program Specialist II	1.7		
Word Processing Technician	1		
Office Technician	1		
	5.7 total		

Second, the five-year bioterrorism grant provided by the Centers for Disease Control (CDC) used to fund 86 of the positions (i.e., 76 limited-term and 10 permanent) will expire on August 30, 2005 and a new multi-year grant will begin. The CDC has yet to finalize specifics on the requirements for the new federal grant funding cycle and it is unclear at this time when this guidance will be forthcoming to the states. As such, it is unclear as to whether all of the requested positions can be funded under the new cycle or whether the CDC will be changing its focus for states.

The table below summarizes the total funds received by the DHS to-date for both the CDC and HRSA grants.

Summary of DHS Funding (as of 12/30/04)	CDC Grant	HRSA Grant	TOTALS
1. Total Federal Funds Received (From 8/31/99 to 8/30/05)	**$195,152,000**	**$87,511,000**	**$282,663,000**
2. State Operations Total Amount	**$60,894,000**	**$35,017,000**	**$95,911,000**
Expenditures	$34,012,000	$12,550,000	$46,562,000
Encumbrances	$12,590,000	$8,403,000	$20,993,000
Remaining Balance	($14,292,000) 23.5 %	($14,064,000) 40.2%	($28,356,000) 29.6%
3. Local Assistance Total Amount	**$134,258,000**	**$52,494,000**	**$186,752,000**
Expenditures	$83,451,000	$3,272,000	$86,723,000
Encumbrances	$47,405,000	$42,532,000	$89,937,000
Remaining Balance	($3,402,000) 2.5%	($6,690,000) 12.7%	($10,092,000) 5.4%
4. Total Summary for the Grants	**$195,152,000**	**$87,511,000**	**$282,663,000**
Expenditures	$117,463,000	$15,822,000	$133,285,000
Encumbrances	$59,995,000	$50,935,000	$110,930,000
Remaining Balance (Not obligated)	($17,694,000) 9.1%	($20,754,000) 23.7%	($38,448,000) 13.6%

Third, the Legislative Analyst's Office (LAO) contends that the Administration overall, including the DHS, Office of Homeland Security (OHS), and others, lacks a unified strategic approach to homeland security, and that only 31 percent of the state's overall homeland security funds have been spent to date.

Specifically regarding the DHS, the LAO notes the following key aspects:

- The OHS, in collaboration with the DHS, should develop a comprehensive homeland security strategic plan and annual expenditure report.
- The DHS needs to expand its monitoring efforts regarding the expenditure of funds for the Local Health Jurisdictions. Though the DHS was provided with new positions in the Budget Act of 2004 to conduct financial and contract management activities for these grants, as well as to monitor Local Health Jurisdiction's expenditures, the LAO recommends for the DHS to include fiscal audits of Local Health Jurisdiction's grant expenditures. (The DHS states that more staff would be needed to do fiscal audits.)
- Since specifics regarding the CDC grant are still pending, the LAO withholds any comment on the DHS request for continuing the 94.8 positions which are expiring as of June 30, 2005.

Additional Information from the Administration Regarding a "Strategic Plan": The Administration has recently informed the Subcommittee that the Office of Homeland Security is drafting a "high level" statewide Strategic Plan for emergency preparedness that is to cover all sectors, including health care, emergency medical services and public health. The DHS will then provide input into this plan which is intended to serve as the overall Strategic Plan for the state.

Further, the DHS is to be undertaking a strategic planning process for public health emergency planning. According to the Administration, this DHS plan will be more detailed than the OHS plan as it pertains to public health. A group of stakeholders are working with the DHS to provide assistance in crafting the plan. According to the DHS, this workgroup includes local health departments and health officers, emergency physicians, hospitals, managed care organizations, clinics, and several state agencies.

Background—Overall Summary: The Emergency Supplemental Appropriations for Recovery & Response to Terrorist Attacks on the US Act (Public Law 107-117 of 2002), and subsequent federal legislation, provided states with additional federal funds to support and address both local and state concerns regarding the threat of bioterrorism.

Under this federal law there are two *key* funding streams made available to California—one from the federal Centers for Disease Control (CDC), and one from the federal Health Resources and Services Administration (HRSA). The CDC grant is in support of state and local public health measures to strengthen the state against bioterrorism via a "Cooperative Agreement" to the DHS. The HRSA grant is for the development and

implementation of regional plans to improve the capacity of hospitals, their emergency departments, outpatient centers, emergency medical systems and related matters.

The DHS notes that they are responsible for detecting and responding to bioterrorism acts. Regardless of source, surveillance of infectious diseases, detection, and investigation of outbreaks, identification of etiologic agents and their modes of transmission, and the development of prevention and control strategies are the responsibility of state and local public health agencies.

Existing State Statute: Existing statute provides a framework for the DHS to contract with, and allocate to, Local Health Jurisdictions for expenditure of bioterrorism funds (local assistance). Among other things, existing statute (1) requires the DHS to develop a plan with representatives of local governments for submittal to the federal government for receipt of the grant funds, (2) requires the DHS to develop a streamlined process for continuation of bioterrorism preparedness funding that will address any new federal requirements and will assure continuity of local plan activities, (3) enables the DHS to contract with public or private entities to meet the federally-approved bioterrorism plan and these contracts shall be exempt from the State Contract Act, and (4) enables the DHS to allocate these funds to Local Health Jurisdictions generally on a per capita basis.

Subcommittee Staff Comment and Recommendation: The federal bioterrorism funds clearly have been difficult for the DHS to administer. Some of this difficulty has been due to a lack of timely guidance by the federal CDC and to the way in which the funds have been provided to the state. However as noted by the LAO, as well as analyses conducted by other independent entities, the DHS needs to engage in a more comprehensive planning and expenditure process where clear outcomes are achieved. It does appears that this is beginning to occur.

Since grant application guidance, as well as the grant award, are still pending from the CDC, it is recommended to keep open the DHS' request to extend the 94.8 positions until the May Revision when hopefully more information is available.

With respect to the LAO recommendations, in lieu of requiring the DHS to perform fiscal audits of each Local Health Jurisdiction, it is recommended to request the Bureau of State Audits to conduct an audit of the state's entire bioterrorism program. Having an independent entity conduct an audit would be helpful and would not require additional DHS resources. Further, the DHS can always utilize its own Audits and Investigations Branch on an as needed basis if they believe a particular Local Health Jurisdiction warrants a fiscal audit or more detailed fiscal review.

It is also recommended to adopt the LAO recommendation to require the DHS to provide the Legislature and the public with an accounting of their expenditures. It is recommended to adopt "placeholder" trailer bill language for this purpose and to direct Subcommittee staff to craft compromise language (i.e., Administration, LAO, and both Subcommittee fiscal staff) for this purpose.

Questions:

1. DHS, Please provide a brief summary of the budget request regarding the need for the requested positions.
2. DHS, Please describe how the local assistance portion of both the CDC and HRSA grant funds are used by the Local Health Jurisdictions.
3. DHS, Please provide a brief status update of the pending CDC grant process. When is California supposed to hear from the CDC regarding application guidance *and* potential funding level?
4. DHS, What outcomes, accomplishments, or goals have resulted from these funds at both the state level, as well as the local level? (Please be specific.)
5. DHS, Specifically, how do you coordinate and monitor expenditures at the local level?
6. LAO, Please present your concerns.
7. DHS, What specifically is the Administration contemplating to address the concerns raised by the LAO?
8. DHS, How will you keep the Legislature informed as to when the CDC provides the state its new guidelines and allocation?

3. AIDS Drug Assistance Program (ADAP)

Issues: *First*, the budget proposes total expenditures of $263.6 million ($91.2 million General Fund, $100.8 million federal funds—Ryan White CARE Act grant, and $71.6 million in drug rebates) which reflects an increase of $18.8 million (total funds) over the current year.

However, due to one-time only adjustments to the ADAP Rebate Fund, a total of $56.2 million ($24.6 million General Fund and $31.6 million drug rebates) is requested as noted in the table (below). The proposed increase is based on actual ADAP expenditures through June 2004 and reflects ongoing cost trends for the program. It is estimated that ADAP will serve 30,446 clients in 2005-06.

Most HIV/AIDS drugs are still under patent protection, so manufacturers can set high prices for antiretroviral drugs which account for 84 percent of ADAP expenditures. Medications to combat opportunistic infections account for an additional 6 percent of ADAP.

Other principle cost factors for ADAP are steadily increasing drug prices and an increasing client caseload. Individuals enrolled in the ADAP often continue in the program for long periods since HIV/AIDS is a chronic illness, and other public and private healthcare are limiting prescription drug coverage.

Summary Table: AIDS Drug Assistance Program (Local Assistance)

Fiscal Year	General Fund	Federal Funds	ADAP Rebates	TOTALS
Budget Act 2004	$66.5 million	$100.8 million	$66.8 million	$234.1 million
• One Time Only			-$26.8 million	-$26.8 million
Revised Baseline	$66.5 million	$100.8 million	$40 million	$207.5 million
Proposed Increase	**$24.6 million**		**$31.5 million**	**$56.2 million**
Proposed 2005-06	**$91.2 million**	**$100.8 million**	**$71.5 million**	**$263.6 million**

Second, the Administration acknowledges that due to the traditional timing of the federal award for the Ryan White CARE Act funds (i.e., April) , as well as the collection of rebate funds, it is likely that the ADAP will be updated at the time of the Governor's May Revision. As such, the General Fund appropriation may need to be adjusted to reflect adjustments to the federal funds as well as the rebates. However the Administration states that ADAP has successfully collected mandatory drug manufacturer rebates over the last seven fiscal years, and in fact, has exceeded the anticipated level in more recent years. Further, it is anticipated that about the same level of federal funds will be awarded to California for ADAP expenditures (i.e., no increase per say is expected).

Third, the DHS is also seeking a state support increase of $230,000 (AIDS Drug Assistance Program Rebate Fund) to fund two state positions for the negotiation of price discounts and manufacturer rebates for ADAP drugs. As such, the total DHS state support budget for ADAP would be $1.430 million ($600,000 General Fund and $830,000 ADAP Rebate Fund).

Fourth, the DHS requested an analysis of the state's ADAP regarding several key areas including: (1) drug purchase model, (2) utilization management, and (3) formulary changes. The University-wide AIDS Research Program (UARP) conducted the state's analysis. Key findings from this analysis include the following:

- *Drug Purchase Models:* The average cost paid by state ADAPs nationally for key anti-retroviral medications does not relate in a statistically significant way to the manner in which the state ADAP Program is organized. Therefore, there is no evidence that California could reduce its drug acquisition costs by changing the purchasing model of its ADAP Program. However, California should explore means of obtaining additional discounts from pharmacies, in addition to rebates from manufacturers.
- *Utilization Management:* Among other things, the analysis noted that the DHS was going to implement a process to enroll prescribers. It is thought that this registration process may provide an opportunity for the ADAP Program to communicate to primary care providers about the cost of different regimens and drugs, and about ways to maintain clinical quality while at the same time reducing costs.
- *Formulary Changes:* Among other things, the analysis noted that 82 percent of ADAP expenditures are spent on anti-retrovirals and 7 percent are spent on opportunistic infections. As such, the potential for cost savings by dropping certain drugs is nominal. Further, dropping some of the drugs may result in substitution of other, possibly higher cost drugs that are retained on the formulary.

Background—ADAP Uses a Pharmacy Benefit Manager: Beginning in 1997, the DHS contracted with a pharmacy benefit manager (PBM) to centralize the purchase and distribution of drugs under ADAP**.** A new contract for this purpose is expected to be tentatively awarded at the end of March. Presently there are about 238 ADAP enrollment sites and about 3,309 pharmacies available to clients located throughout the state.

Background—ADAP Drug Rebates (Federal and State Supplemental): Both federal and state law require ADAP drug manufacturer rebates to be paid in accordance with the same formula by which state Medicaid (Medi-Cal) programs are paid rebates. This formula is established by the federal Center for Medicare and Medicaid (CMS). Due to federal restrictions regarding the rebate calculation formula, the actual calculation (i.e., the specific multiplier) is not available to the state or the public. *Therefore, the actual rebates that California actual receives varies by the amount invoiced to the drug manufacturer.*

In addition, California also negotiates additional "supplemental" rebates under ADAP via a special national taskforce, along with eight other states (representing the largest ADAP's in the country). The mission of this taskforce is to secure additional rebates from eight manufacturers of antiretroviral drugs (i.e., most expensive and essential treatment therapies). The rebate arrangements vary by manufacturer and may change annually or upon renewal of manufacturer agreements. These efforts have been very successful in the past. The DHS also notes that they have also begun to negotiate supplemental rebates on non-antiretroviral drugs.

The Omnibus health trailer legislation to the Budget Act of 2004 established a special account in which all ADAP drug rebates are now deposited. This was done in order to better track and account for the rebates, as well as to define the parameters for their expenditure.

Background—How Does AIDS Drug Assistance Program Serve Clients? ADAP is a subsidy program for low and moderate income persons (individual income cannot exceed $50,000) with HIV/AIDS who have no health care coverage for prescription drugs and are *not* eligible for the Medi-Cal Program. On average, ADAP clients access the program an average of 7.4 months per year.

ADAP is cost-beneficial to the state. Without ADAP assistance to obtain HIV/AIDS drugs, infected individuals would be forced to (1) postpone treatment until disabled and Medi-Cal eligible or (2) spend down their assets to qualify for Medi-Cal. About 50 percent of Medi-Cal costs are borne by the state, as compared to only 28 percent of ADAP costs.

Under the program eligible individuals receive drug therapies through participating local pharmacies under subcontract with the statewide contractor**.** The state provides reimbursement for drug therapies listed on the ADAP formulary (about 153 drugs currently). The formulary includes anti-retrovirals, opportunistic infection drugs, hypolipidemics, anti-depressants, vaccines, analgesics, and oral generic antibiotics.

Since the AIDS virus can quickly mutate in response to a single drug, medical protocol now calls for Highly Active Antiretroviral Treatment (HAART) which minimally includes three different anti-viral drugs. Studies consistently demonstrate that early intervention, minimizes more serious illness, reduces more costly treatments and maximizes an individual's productivity and health.

Subcommittee Staff Comment and Recommendation: Based on current information, it is likely that the DHS will obtain increased rebates under ADAP and that the federal Ryan White CARE Act funds will be about what California is presently receiving.

However, since ADAP is a caseload-driven program, the pharmacy benefit manager contract is still pending award, and the receipt of both federal funds and drug rebate funds will be clearer in a few weeks, it is recommended to hold this item open pending any additional May Revision adjustments. The awarding of the contract will likely provide additional detail regarding anticipated expenditures.

Questions:

1. DHS, Please provide a brief summary of the budget request.
2. DHS, Please describe key cost containment measures that have been recently implemented.
3. DHS, Please provide brief comments regarding the key aspects of the UARP report. Are there any additional cost-containment options which would not hinder ADAP client compliance with the drug regimen that the Administration is considering for implementation?

4. DHS, Please provide an update as to the pending status of the federal Ryan White CARE Act funds. Is it likely that California will receive about the same amount as presently noted in the Governor's proposed budget?

5. DHS, Please provide an update on the status of California's participation in the national taskforce's efforts to capture drug manufacture rebates. Is it likely that California will obtain about the same amount as presently noted in the Governor's proposed budget or more?

6. DHS, Please provide an update on the status of the ADAP pharmacy benefit manager contract.

4. Domestic Violence Shelter Program—Unserved and Underserved (U/U)

Issues: *First,* the Administration proposes an increase of $1.1 million ($515,000 General Fund, $235,000 Domestic Violence Training Fund and $350,000 in Nine West Settlement Funds) to restore funds used to assist shelters to serve communities of color, teens, disabled women and others that traditionally do not seek shelter services but are at high risk for domestic/intimate partner relationship violence. It should be noted that this is a direct service program and not an outreach program.

According to the DHS, they define "unserved and undeserved" populations with descriptors such as ethnicity, age, culture, sexual preference, language, literacy level, geography, physically challenged, and other criteria that inhibit access to services.

Second, it is not yet clear on how the DHS intends to allocate these unserved and underserved funds if approved for appropriation. Historically, a Request for Application was used to allocate these funds. Yet in more recent times, the funds have been allocated directly to the shelters for their use as they determine. As such, accountability on whether these funds were actually used to address needs has not always been monitored effectively.

The DHS has noted that they are presently conducting a survey to better determine and identify the needs in this area, and to vastly improve the monitoring and accountability of the expenditure of these funds for the purpose of better serving unserved and underserved communities.

Background on the Need for Unserved and Underserved Funds: Anecdotal information supports that some populations who are experiencing domestic violence do not generally access shelters as often as other populations. For some communities, the use of shelter programs and the identification with domestic violence are not culturally relevant or appropriate. Although one's sexual preference, culture, poverty and age are not causes of domestic violence, some communities have unique cultural differences, differing traditions and beliefs, and speak different languages that need to be taken into account when working with these communities.

It is well recognized that societal problems related to domestic violence must be addressed in a comprehensive and multi-faceted manner to gain a full appreciation of the complex role that culture plays in program development and service delivery.

Subcommittee Staff Comment: Since the DHS is still awaiting the results of their survey, the Subcommittee may want to hold this item open pending the results of the survey and clearer direction on how the funds are to be allocated.

Background—Domestic Violence Shelter Program: A total of $22.9 million ($22.3 million General Fund) is proposed for the DHS program. Of this amount, (1) $21.3 million is allocated to 97 shelters for services, (2) $262,00 is for data management and a women's health survey, (3) $85,000 is for technical assistance and training as required by statute, and (4) $1.1 million is for unserved/underserved individuals. The existing program was established in statute in 1994 (AB 167, Freidman).

It should be noted that as a condition of receiving funds, shelters must, among other things, provide matching funds or in-kind contributions equivalent to not less than 20 percent of the grant they would receive.

Questions:

1. DHS, Please describe how these funds can provide a vital linkage to communities.
2. DHS, Please briefly describe how the department conducts over sight for this program.
3. DHS, Please provide an update on the status of the survey and its intended use.
4. DHS, When will you have a more definitive idea as to how the funds will be allocated and what type of monitoring and accountabilities will there be with these funds?

5. New Born Screening Program Adjustments

Issue: SB 142 (Alpert), Statutes of 2004, expanded the existing Newborn Screening Program from 39 conditions to 76 conditions through the use of Tandem Mass Spectrometry. This expansion is the product which resulted from a Pilot Project (AB 2427, Kuehl, Statutes of 2000) which operated from January 2002 through June 2003. The pilot ended when one-time funding from the Genetic Disease Testing Fund was expended.

To fund this expansion effort, the DHS is requesting an increase of $15 million (Genetic Disease Testing Fund) to (1) support three new positions, and (2) purchase $14.8 million in equipment and related services, including Tandem Mass Spectrometry equipment and software, laboratory services, and information processing system modifications.

The three requested positions include one Public Health Chemist, one Research Scientist IV, and one Staff Services Analyst.

The enabling statute provided the DHS with authority to increase fees for this program, if required for the expansion effort. As such, the DHS is proceeding with emergency regulation authority to increase the fee from $60 to a total of $78, effective January 1, 2005.

According to statute as contained in SB 142 (Alpert), Statutes of 2004, the expanded program is to be up and operational by August 1, 2005.

Background—Newborn Screening Program: The Newborn Screening Program screens about 525,000 infants, or 99 percent of the annual births, in about 325 maternity hospitals. Newborns are screened for a series of heritable preventable metabolic disorders. At the time of birth, the heel of the infant is pricked and a drop of blood tested for different disorders. Birth defects often have no immediate visible effects on a baby but unless detected and treated early, can cause physical problems, mental retardation, and death.

When test results are abnormal, early diagnosis and proper treatment can make the difference between lifelong impairment and healthy development. Further, significant cost savings can be achieved through early detection and in some cases, simple dietary treatment of some disorder. Cost benefit analyses have found that expanded newborn screening produces significant net benefits. The DHS estimates that for every dollar spent on expanded screening, two dollars and fifty-nine cents ($2.59) is saved in average lifetime medical costs alone.

All screening is fee supported and is voluntary. Fees are collected from individuals, their health insurance, hospitals, birthing centers and the Medi-Cal Program. All fee collections are deposited in the Genetic Disease Testing Fund.

Subcommittee Staff Comment and Recommendation: The proposal is consistent with the enacted legislation. It is recommended to approve as budgeted.

Questions:

1. DHS, Please describe the budget request to fund the three positions and to purchase equipment and related services (including all of the contracts).
2. DHS, Please provide a comprehensive update on the status of the different implementation aspects for expanding the program as required.
3. DHS, What is the status of the emergency regulations to increase the fees?
4. DHS, Please provide comment regarding the fund condition statement for the Genetic Disease Testing Fund. What level of revenues and expenditures is the DHS projecting?

6. Richmond Laboratory—Phase III

Issue: The budget reflects a *net* savings of $1.640 million ($820,000 General Fund) for implementation of the "Phase III Office Building" of the Richmond Laboratory which is scheduled for completion by March 2005. This net savings reflects the interaction of savings from rent related to a building move and potential expenditures related to operating the new building.

The DHS states that occupancy of the new building will begin in late 2004-05 with the relocation of 170 staff from the DHS' old facility. This initial relocation is to be accomplished with existing funds. In 2005-06, the majority of the 625 staff will be moved from various leased space into the new building during the Summer of 2005.

Specifically, this budget-year proposal consists of a request to establish 6 new state positions and to fund certain operating equipment.

The proposed *net savings* result from the following adjustments:

- *Savings of $3.629 million* ($1.8 million General Fund, and $1.8 million in various special funds) from reduced rent due to the vacated lease from the old building.
- *An increase of $2 million* ($996,000 General Fund, and $979,000 special funds) for the following adjustments:
    - $457,000 ($229,000 General Fund, and $228,000 special funds) to support 6 new state positions. This includes the following personnel: (1) an Office Building Manager I, (2) a Staff Services Analyst, (3) three Stationary Engineers, and (4) an Office Technician. This also includes their operating expenses.
    - $77,000 one-time only for the purchase of equipment, including (1) electric carts (2 carts at $8,000 each), (2) various ladders, tools and tool carts ($5,000), (3) parking lot lighting repair service unit (1 at $50,000), and (4) electronic security cameras (3 at $2,000).
    - $188,000 for a moving contract.
    - $350,000 for utilities.
    - $917,000 for other contracts including landscaping, janitorial and security.

The DHS states that of the $2 million increase, $1.7 million will be on-going and $265,000 will be one-time only.

Additional Background Information: According to the DHS, the construction of the 200,000 square foot building is to be completed as of June 2005.

Presently there are 46.6 DHS maintenance staff that manage the Richmond Laboratory complex. The 6 new positions being requested would be an addition to this staff.

Questions:

1. DHS, Please describe the proposal and the need for the expenditures.